



Name: _____

Date of Birth: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

The most important factor in receiving good healthcare is to give specific medical information to your health care provider and staff. Keeping permanent records of your medical history promotes better communication between you and your provider in ensuring you get the best care possible.

As the patient you have the right to:

- Receive complete, accessible and quality health care and information that is provided in a respectful and timely manner.
- Ask questions. It is very acceptable to ask questions of your doctor. Continue to ask questions until you understand. Write down answers, or record answers with a tape recorder so you don't get confused. Call back to ask additional questions. Take a friend or family member so they can get the information or ask questions. They may hear things you miss.
- Obtain the necessary information to make an informed decision regarding your health.
- Receive privacy and confidentiality regarding your symptoms, treatment, tests and medication.
- Request and receive copies of your medical records and written reports.

Providing the correct information about your health is central to a successful visit to your doctor's office. Your relationship with your doctor is a partnership. Use this booklet as a guide for providing your doctor with the following information:

- A list of symptoms you're experiencing. Don't be shy, ashamed or embarrassed about asking questions. Tell the truth. This is your health and

accuracy is important. List the most severe and most problematic symptoms first. Be specific. How long have you had them? When did they occur? What makes the symptoms better? Or worse?

- A list of questions for the doctor. Have your health history and drugs, with dosages, you are taking.
- Your medical background/health history. Accuracy is essential! Write down your health history and add to it as the years go by.
- A description of your pain – where, how, and how much your symptoms hurt. Tell the doctor if the pain is sharp, dull, burning, etc. Pain scales are very common and are used to help describe pain. A pain scale is 0-10, with 0 being no pain and 10 being unbearable pain.
- A list of prescription medication, herbs, supplements, vitamins and over the counter medications you are taking on a regular basis, or that you have taken or applied topically to relieve your symptoms. Accuracy of dosages is important. You can list these in your health history.

Be patient and allow your doctor some quiet time to think about what you are sharing with her/him and to review your chart. This will give her/him the opportunity to better diagnose and treat your symptoms. Be sure to answer the doctor's questions in a straightforward, direct manner.

For more information about your health:

Michigan Department of Community Health - www.michigan.gov/mdch or (517) 373-3740. U.S. Center for Disease Control – www.cdc.gov or 1-800-311-3435

Health Insurance

Provider: _____

Policy Number: _____

Phone: _____

Contact Person: _____

Emergency Contact or Nearest Relative

Name: _____

Relationship: _____

Address: _____

City/State/Zip: _____

Phone: _____

Pharmacy

Name: _____

Location: _____

Phone: _____

Yes, I have a:

- ☐ Living Will
- ☐ Health Care Agent (Proxy)
- ☐ Health Care Power of Attorney

Documents are kept at:

For more information about living wills and power of attorney:

Go to www.michigan.gov/LTC and click on “Planning Ahead” then “Legal Options”

My Doctor's Information

Primary care doctor

Name	Address	Phone/Fax
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Other doctors

Name	Address	Phone/Fax	Specialty
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Family Medical History – (cancer, diabetes, osteoporosis, high blood pressure, heart disease, etc.)

Relative

Disease or Illness

[illegible]

Medical History – (serious illnesses, childhood illnesses, birth defects, etc.)

Type

Age

[illegible]

Accidental Injury

Type	Date	Doctor / Location
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Type	Date	Doctor / Location
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Type	Date	Doctor / Location
------	------	-------------------

[illegible]

Allergies (*drug, food, environmental*)

Type	Symptoms	Medications
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Type	Symptoms	Medications
------	----------	-------------

Type	Symptoms	Medications
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Medications I am taking – (prescriptions, over-the-counter, supplements, etc.)

Medication	Purpose/Illness	Dosage	Frequency
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[illegible]

Surgeries/Procedures

Type	Date	Hospital	Attending Physician
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Immunizations/Vaccinations

Type	Date Given	Doctor / Location
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Test/Screening:

Date/Results

Date/Results

Mammogram

Pap Smear

Bone Density Test

Blood Pressure

Weight

Cholesterol

Physical Exam

Discuss Smoking Cessation

Colonoscopy

Diabetes

Symptoms I have: Questions I have for my doctor:

[illegible]

(Bring this list of symptoms and questions with you when you go to the doctor's office)



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